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Skin disease in Lambeth

A community study of prevalence and use of medical care

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Kentish Town Health Centre[1], The London School of Hygiene and Tropical Medicine[2], and The University of London[3]

Rea, J. N., Newhouse, M. L., and Halil, T. (1976). *British Journal of Preventive and Social Medicine*, 30, 107-114. Skin disease in Lambeth: a community study of prevalence and use of medical care. A community survey of skin disease was carried out in Lambeth, London. A postal questionnaire asking recipients to give details of the presence of skin disease was sent to a stratified sample of 2180 adults; a subsample of 614 persons were interviewed at home and an inspection was made of the exposed parts of their skin. Altogether 92 conditions were identified. These were graded for clinical severity and classified into 13 groups. The overall prevalence of skin disease thought to justify medical care was 22·5%. The most common important condition was eczema with a prevalence of 6·1%. Age, sex, and social class trends in prevalence were found in certain groups of skin disease. Of those with a skin disease thought to justify medical care, only 21% reported having attended their general practitioner in the past six months for a skin complaint. The reported use of medical care and self medication is discussed in relation to the presence of skin disease and other factors.

Skin disease forms a substantial part of the total spectrum of ill health. Since most skin disorders are not disabling and have a negligible mortality they are treated mainly at the general practice or outpatient level of care, and self medication is very common. Studies from general practice (Logan and Cushion, 1958; Barker, 1968; Morrell, 1970) show that between 7 and 11% of patients registered with a general practitioner attend at least once each year with a skin complaint. The actual prevalence or incidence of skin disease in the community has, however, never been determined in this country.

Most epidemiological studies of skin disease have been based on those who present themselves for treatment—a method which is of value only to indicate the approximate prevalence of the more severe forms of skin disease. Population studies have tended to concentrate on specific skin diseases or selected groups—for example, military recruits or mental hospital patients. Studies of complete communities have been carried out in the Faroe Islands by Lomholt (1964) and in Sweden by Hellgren (1967). A previous study by one of us (Newhouse, 1964) provides a basis for comparison with the present study in an industrially-employed group of men of working age in the south of England.

A community survey of skin disease carried out by the Department of Clinical Epidemiology and Social Medicine on a random sample of the population of north Lambeth is described. This was the third of a series of four community studies on this population carried out between 1967 and 1969. Each survey was designed to estimate the prevalence and medical care needs of a different group of common disorders.

Social and psychological data which might be relevant to aetiology or use of medical care were also obtained. The overall aims and strategy of the surveys are described elsewhere (Holland and Waller, 1971).

METHOD

The survey was carried out in two phases. Phase I was a screening process to identify individuals with a rash or other disorder of the skin, hair, and nails (excluding male baldness or brittle nails) by means of a postal questionnaire. In Phase II, three-quarters of the individuals responding positively in Phase I, and one-fifth of those responding negatively, were visited by one of a team of seven doctors (two senior and two other registrars in dermatology, and three other doctors) and 11 nurse

field-workers who had received training in the recognition of common skin disorders from one of the dermatologists. The doctors mainly, but not exclusively, visited positives.

Interviewers administered a structured questionnaire which asked for details of occupation, demographic data, and use of medical care during the previous six months. Exposed parts of the skin (face, hair, scalp, neck, forearms, hands, lower legs, and knees) were inspected in all cases and respondents were asked to complete the IPAT Anxiety Scale Questionnaire (Cattell and Sheier, 1963). The extent of the skin conditions seen was indicated on a body diagram and its severity graded on a three-point scale. It proved difficult to agree on objective criteria for grading the severity of all forms of skin disease. In effect, the grading was largely clinical with the following guidelines:

Trivial—in the opinion of the observer not justifying medical attention—that is, very minor or 'paraphysiological' conditions

Moderate—justifying medical attention

Severe—needing early medical attention because of severe symptoms or likelihood of progression (for example, disfiguration, potential malignancy, or interference with work or daily living).

The findings in the field were classified on return to base and repeat visits were made to certain respondents in which the diagnosis was uncertain. Diagnoses were recorded according to the code in the *International Classification of Diseases*. In all 92 distinct diagnoses were made, and up to six of these were recorded on certain individuals. The diagnoses were grouped into 13 main categories (see Appendix). These groupings were necessary in a sample survey of this type in which comparatively few cases of each individual diagnosis were seen so that prevalence rates could be calculated. So far as possible, each group comprised allied conditions but some inevitably had a 'ragbag' of unrelated skin disorders. The proportionate composition of each group is given in the Appendix.

Population, Sample and Response Rate

The sample for Phase I was drawn from two sampling frames. A sample of 1220 individuals aged 15 to 74 years inclusive was selected from the St Thomas's Hospital Private Census (Bennett and Kasap, 1970). This was an age, sex, and social class stratified random sample with probability of selection disproportionate to size of stratum. Disproportionate sampling fractions were used because of the skewed age, sex, and social class distribution of the study population and to ensure adequate numbers of individuals in each stratum for estimation of prevalence rates, age, sex, and social class trends. A further independent sample of 1074 individuals was selected from the most recent Electoral Register to compare the effectiveness of the two sampling frames. Simple random sampling within each sex was used.

Because of death and other reasons the effective sample sizes were 1200 for the private census and 987 for the Electoral Roll. After three reminder letters and visiting of persistent non-respondents, replies were obtained from 90·5% of the subjects (Table I). The main reason for non-response was that the respondent had moved out of the survey area or to an unknown address (8·8% of the sample).

The population for Phase II (interview and examination) was a random sample of 638 subjects consisting of three-quarters of the positive and one-fifth of the negative respondents of Phase I.

TABLE I

RESPONSE RATES IN PHASE I AND PHASE II BY SAMPLING FRAME

Sampling Phase	Private Census		Electoral Register		Total	
Screening phase	1200		987		2187	
Response	1056 (88·0)		923 (93·5)		1979 (90·5)	
Classification at screening	Positive 230	Negative 826	Positive 209	Negative 714	Positive 439	Negative 1540
Interview phase	168	157	159	154	327	311
Response	163 (97·0)	146 (93·0)	152 (95·6)	153 (99·3)	315 (96·3)	299 (96·1)

Percentages are given in parentheses

The response rate in this phase (96·2%) was higher than for Phase I (90·5%). The main reason for non-response was again because the respondent had moved out of the survey area or to an unknown address (3·1%); four subjects refused to co-operate.

Results

Validity of Screening Questionnaire

The screening questionnaire was not highly discriminating. Of those answering positively, 14% were found to have no detectable skin disease; of the negatives, 13% were found to have moderately severe skin disease. These false positive and false negative rates did not alter with time between the screening questionnaire and inspection. This degree of error had been predicted in a pilot study. The purpose of the screening stage was to enrich the second stage with examples of skin disease, since it would otherwise have been necessary to visit more than twice as many individuals to obtain the same number of cases.

Prevalence of Skin Disease

The prevalence by sex and grade of severity of each of the 13 groups of skin disease is given in Table II. The effects of age and social class in some of these groups of skin diseases are shown in Tables III and IV. In each of the tables, the estimates have been adjusted to allow for the effect of the other variables (sex, age, or social class).

The estimation of prevalence rates and their standard errors was based on a procedure which took into account first the dependence of skin diseases on sex, age, and social class; secondly the errors of classification due to the low discriminating power of the screening questionnaire; and thirdly the disproportionate sampling fractions used in stratified sampling. The estimated prevalence rates shown in Tables II-IV are based on individuals drawn only from the private census since the estimation process required knowledge of the age, sex, and social class distribution of the inference population. Information on age and social class was not available for the Electoral Roll sample.

Table II

ESTIMATED PREVALENCE OF 13 GROUPS OF SKIN DISEASE PER 1000, AND STANDARD ERRORS, BY SEX AND GRADE OF SEVERITY‡

Skin Condition	Both Sexes		Male		Female	
	All Grades	Moderate and Severe	All Grades	Moderate and Severe	All Grades	Moderate and Severe
Tumours and vascular lesions	204·7 ± 22·7	14·1 ± 5·6†	141·9 ± 27·2**	0·6 ± 0·9**	264·1 ± 35·9**	26·8 ± 10·8**
Eczema	90·1 ± 17·0	61·2 ± 14·3	99·5 ± 24·9	80·2 ± 24·2	81·1 ± 23·1	43·4 ± 15·8
Acne	85·9 ± 14·5	34·6 ± 8·1	109·0 ± 24·2	34·5 ± 12·0	64·1 ± 16·5	34·7 ± 11·0
Scaly dermatoses	84·7 ± 17·2	28·7 ± 10·9	118·3 ± 28·3**	39·2 ± 18·7*	53·0 ± 19·9**	18·9 ± 11·8*
Scalp and hair disorders	82·1 ± 16·2	13·6 ± 6·2	79·0 ± 22·6	7·9 ± 6·1	95·0 ± 23·3	18·9 ± 10·0
Prurigo and allied conditions	82·1 ± 16·2	38·9 ± 12·6	60·8 ± 20·9	16·9 ± 11·6	95·0 ± 25·9	59·6 ± 21·9
Erythematous and other dermatoses	75·0 ± 16·6	21·4 ± 9·3	30·9 ± 12·4**	20·8 ± 10·6	116·8 ± 30·2**	22·0 ± 15·1
Infective and parasitic conditions	46·0 ± 14·0	6·7 ± 4·9†	48·2 ± 20·1	10·9 ± 8·4†	43·9 ± 11·6	2·8 ± 5·2†
Warts	34·3 ± 10·5	1·5 ± 1·4†	35·9 ± 16·4	— —	32·8 ± 13·4	2·8 ± 2·7†
Nail disorders	33·0 ± 11·1	18·8 ± 9·6†	23·9 ± 16·5	12·5 ± 14·5†	41·7 ± 15·0	24·8 ± 12·6†
Psoriasis	15·8 ± 8·9	5·8 ± 4·9†	24·4 ± 15·5	3·7 ± 3·6†	7·7 ± 9·0	7·7 ± 9·0†
Mouth and tongue disorders	8·9 ± 5·7	0·7 ± 0·9†	15·4 ± 11·5	— —	2·7 ± 2·5	1·3 ± 1·8†
Chronic ulcer	1·7 ± 2·0*	— —	3·5 ± 4·2†	— —	— —	— —
Any skin condition	554·7 ± 30·0	225·0 ± 23·9	479·1 ± 40·5	213·0 ± 34·0	606·7 ± 44·2	236·0 ± 33·6

‡ Age and social class adjusted

†These estimates based on 5 cases or fewer * P = <0·05 ** P = <0·01 (significance of sex differences)

TABLE III

ESTIMATED PREVALENCE OF CERTAIN SKIN DISEASE (PER 1000), BY AGE GROUP AND GRADE OF SEVERITY†

Grade of Severity	Age Group							
	Age 15-24 (years)		Age 25-34 (years)		Age 35-54 (years)		Age 55-74 (years)	
	All Grades	Moderate and Severe	All Grades	Moderate and Severe	All Grades	Moderate and Severe	All Grades	Moderate and Severe
Eczema	122·7	72·6	35·4	34·2	126·5	89·4	64·4	38·0
Acne	273·2***	137·8***	78·7	34·5	57·2	8·9	20·3	8·6
Scaly dermatoses	60·5	9·8	35·3	14·0	56·4	40·1	173·0*	35·8
Prurigo and allied conditions	66·8	38·4	42·4	34·4	122·6	32·6	54·0	50·8
Erythematous and other dermatoses	14·2	—	99·4*	4·1	89·4	15·2	73·0	55·1
Warts	61·5	—	35·3	7·1	3·1	—	59·1	—
Psoriasis	4·2	—	51·6	23·2	—	—	16·4	3·6
Any skin condition	614·1	308·0	543·3	246·0	514·0	186·0	545·9	211·0

† Sex and social class adjusted
Significance of age difference * P <0·05 *** P <0·001

TABLE IV

ESTIMATED PREVALENCE OF CERTAIN SKIN DISEASE (PER 1000) BY SOCIAL CLASS AND GRADE OF SEVERITY†

Grade of Severity	Social Class							
	I + II		III NM		III M		IV + V	
	All Grades	Moderate and Severe	All Grades	Moderate and Severe	All Grades	Moderate and Severe	All Grades	Moderate and Severe
Eczema	74·0	50·3	47·1	19·3	133·3	116·3	73·5	31·5
Acne	56·0	46·5	98·3*	72·2	81·8	4·1	90·7	42·5
Scaly dermatoses	46·1	2·3	90·9	24·3	92·8	47·9	82·9	18·6
Prurigo and allied conditions	40·1	11·6	86·4	45·8	81·0	34·0	80·9	45·5
Erythematous and other dermatoses	97·4	39·1	58·0	10·8	48·9	—	103·6	43·3
Warts	7·7	—	48·8	7·9	43·1	—	24·9	—
Psoriasis	27·2	13·3	7·2	3·6	33·8	11·0	—	—
Any skin condition	617·7	180·2	489·9	236·4	539·9	246·9	559·7	208·8

† Sex and age adjusted
Significance of social class difference * P <0·05

The group 'tumours, naevi, etc.' had much the highest overall prevalence but the majority (90%) of conditions in this group were of 'trivial' grade—that is, did not require medical care (Table II). In the eczema group on the other hand, with less than half as high an overall prevalence, more than two-thirds (68%) were graded moderate/severe so that the highest prevalence (61·2/1000) of conditions justifying medical care fell into this group. The second highest prevalence of moderate/severe conditions (38·9/1000) was found in the group 'prurigo and allied conditions'. Both of these groups are characterized by skin irritation which can often be relieved by treatment, and are likely therefore to have been classified as at least moderately severe.

Age, sex, or social class effects were not found when all forms of skin disease were considered together since several conditions had trends in opposite directions, so that their effect was cancelled when they were pooled. Taking the 13 groups of conditions separately certain differences in prevalence according to age, sex, or social class were

evident; those which were significant are indicated in the tables. Possible reasons for these are discussed later. In no group was a social class trend with increasing or decreasing prevalence from Social class I to social class V found.

Observer Variation

It was not possible to arrange for repeat examinations by different observers of more than a very few respondents. However the results of individual observers and groups of observers have been compared. It was found that the two senior registrars recorded more than twice as high a prevalence of 'benign tumours, naevi, etc.' as the other observers (including the other dermatologists). For other common conditions there was greater consistency among the four dermatologists but the senior registrars tended to grade more conditions as moderate or severe (justifying a consultation). The estimated prevalence given in the tables have not been adjusted to account for these differences since each observer saw relatively few cases.

Use of Medical Care

In the second phase of the survey respondents were asked if they had seen their general practitioner, attended a hospital outpatient department, or been admitted to hospital within the past six months. They were also asked whether this had been for a skin condition, for 'nerves or depression', or for some other condition. In addition they were asked if they were currently using a prescribed preparation for their skin, or a preparation they had themselves bought from a chemist other than a cosmetic (self medication). Use of tranquillizers or hypnotics was also recorded.

The reported use of medical care by those interviewed is given in Table V. These figures are higher than would have been obtained by interviewing a random sample of the general population, since half of those interviewed had answered the screening questionnaire positively, indicating the presence of a skin condition.

There was a higher use of general practitioners' services by women, but this reached significant proportions only for attendance for 'nerves' and use of hypnotics or tranquillizers. On the other hand use of prescribed preparations, hospitals, or self medication did not differ between the sexes.

Table VI shows the use of certain types of medical care by those with different groups of skin disease according to the classification of severity. For conditions other than acne, not unexpectedly, there was a greater tendency to consult general practitioners for moderate/severe conditions than for trivial ones; this trend was not evident for hospital treatment. Self medication was used more often for trivial than for moderate or severe conditions. Between 41 and 58% of those with moderate or severe eczema, acne, or psoriasis, however, reported they had not sought any treatment within the last six months.

The different forms of medical care were used fairly equally by people of all ages although there was a slightly greater tendency for those in the youngest age-group to make use of their general practitioner or to treat themselves. Those over 55 years of age reported slightly more use of hospital skin outpatient services, they also received more prescriptions for tranquillizers and hypnotics. There were few social class differences in the use of medical care; however, there was a tendency for those in social classes I and II to make less use of their general practitioner and resort to self medication more frequently.

TABLE V

USE OF MEDICAL CARE IN PREVIOUS SIX MONTHS FOR SKIN AND OTHER COMPLAINTS ACCORDING TO SEX

Medical Care	Males (n = 311) per 1000	Females (n = 303) per 1000
General practitioner consultations		
For skin complaints	96	129
nerves	23***	99***
other complaints	399	475
Hospital attendance		
Outpatients:		
For skin	35	30
other complaints	180	228
Inpatients:		
For skin	3	3
other complaints	58	56
Use of prescribed medication		
For skin	116	119
Hypnotics or tranquillizers	39***	112***
Other medication	203	211
Self medication for skin (other than cosmetics)	167	168
Non medical advice for skin (chemist, nurse, etc.)	39	46

*** P = <0·001 = Significance of sex difference

Discussion

The prevalence of various conditions reported here is higher than those reported by Lomholt (1964) in a total population study of the Faroe Islands who reported 4·2% of men and 6·1% of women with skin disease 'requiring treatment'. This clinical assessment of medical need probably falls between the grades of 'moderate' and 'severe' in the present study.

TABLE VI

USE OF MEDICAL CARE FOR CERTAIN GROUPS OF SKIN DISEASE BY GRADE OF SEVERITY

Group	Grade of Severity	No. of Persons (= 100%)	Self Medication	General Practitioner	Hospital		Use of any Medical Service	No Treatment
					Outpatient	Inpatient		
Eczema and prurigo ..	Trivial	57	27 (47)	7 (12)	3 (5)	— —	8 (14)	26 (45)
	Moderate/Severe	100	35 (35)	27 (27)	6 (6)	— —	30 (30)	41 (41)
	All grades	157	62 (39)	34 (22)	9 (5)	— —	38 (24)	67 (43)
Acne	Trivial	40	17 (42)	9 (22)	1 (3)	— —	9 (22)	18 (45)
	Moderate/Severe	43	14 (31)	5 (12)	1 (2)	— —	6 (14)	25 (58)
	All grades	83	31 (37)	14 (16)	2 (2)	— —	15 (18)	44 (53)
Psoriasis ..	Trivial	6	— —	— —	1 (17)	— —	1 (17)	5 (83)
	Moderate/Severe	11	2 (18)	3 (27)	1 (9)	— —	4 (4)	6 (55)
	All grades	17	2 (12)	3 (18)	2 (12)	— —	5 (29)	11 (65)
All other conditions ..	Trivial	215	70 (33)	18 (8)	6 (3)	1 (0·5)	22 (10)	130 (60)
	Moderate/Severe	94	28 (30)	19 (20)	7 (7)	— —	23 (24)	48 (51)
	All grades	310	98 (31)	37 (12)	13 (4)	1 (0·3)	45 (14)	178 (57)

Many persons received more than one type of medical care
Percentages are given in parentheses

In the group 'tumours, naevi, etc.' there was a consistent tendency for women to have a higher prevalence ($P<0·01$). This was recorded by all groups of observers. It is possible that women drew more attention to these small lesions than men, or that the observers had a higher tolerance for them in men and were therefore less likely to record them in men than in women, but it may well represent a real difference in prevalence.

A high prevalence of eczema has often been reported, and the present figures confirm those of Newhouse (1964) who found eczematous lesions in 7·1% of car workers. Of these 2·8% were of endogenous and 4·3% of exogenous, probably industrial, origin. In the present study 23% (26/111) of all eczemas were thought to be of 'contact' or occupational origin—that is, exogenous in nature.

Moderate or severe eczema was more common in men, particularly manual workers of social class III. A possible explanation of this could be that this social class group is particularly likely to come into contact with industrial substances which might exacerbate any eczematous tendency. A further finding (not shown in the tables) was for moderate or severe eczema to increase with age in men but decrease in women; however this did not reach statistical significance at the 5% level.

The prevalence of acne was, as expected, highest in the age-group 15-24 years with a highly significant linear trend inversely proportionate to age. Males had a higher overall prevalence (although not reaching a significant level) but more severe acne was equally common in both sexes.

More than a quarter of the lesions in the 'scaly dermatosis' group consisted of seborrhoeic keratoses, and it was thus not surprising that there was a significant rise in prevalence with increasing age. The male predominance was largely due to the inclusion of sycosis barbae and ichthyosis in this group.

Most of the 'scalp and hair disorders' group consisted of pityriasis capitis (dandruff). This was recorded only if excess seborrhoeic scales were present on inspection; self medication by many respondents had removed this so that the actual prevalence is likely to have been higher than that recorded. Scalp and hair disorders were more commonly recorded in younger people but there was no linear age trend.

The group 'prurigo and allied disorders' was more common in women especially in the moderate/severe grade. It included chronic, irritant, non infective conditions, some with an allergic basis such as urticaria, lichen simplex, and pruritus ani and vulvae. Both groups included a high proportion in the moderate/severe grade; the need for treatment for skin irritation would influence this grading.

'Erythematous and other dermatoses' included a group of somewhat disparate mostly non-irritant conditions with the common characteristic of alteration of the vascularity or pigmentation of the skin. The two most common diagnoses were chilblains (7) and acne rosacea (5). Females had a higher overall prevalence than males but there was no sex difference in the moderate or severe categories.

The overall prevalence of infective and parasitic conditions was 46/1000; most were considered

to be trivial in degree. Nearly half of them were probably fungal infections (routine microscopy of scrapings from these lesions was not practicable). These conditions are mainly of short duration so that in a 'point prevalence' survey such as this they are likely to be under recorded. Studies in General Practice (Logan and Cushion, 1958) suggest that approximately half of all skin conditions fall into this or the next group.

A higher prevalence of infective warts would have been found if children under 15 years had been included; systematic inspection of feet would also have revealed asymptomatic verrucae. Nevertheless the figures given confirm the high prevalence of warts in the community. Logan and Cushion's data (1958) show that only 0·5% of the population over 15 years consult each year with infective warts; the actual prevalence appears to be about six times as great.

The overall prevalence of 1·6% of psoriasis is in line with other estimates in the United Kingdom—for example, Ingram (1964) who estimated the prevalence as 2%, but lower than that described in Sweden by Hellgren (1967) (3·3%), and in the Faroe Islands by Lomholt (1964) (2·5%). The very considerable (and statistically significant) sex difference was unexpected. Some previous studies have shown a higher prevalence in men (Hellgren, 1967; Yasuda, 1971) but none with such a marked difference. In clinical practice women present as commonly as men; It is however probable that many men suffering from mild psoriasis do not present for treatment.

Chronic ulcer was present only in the oldest age-group and there was a low prevalence. (The true prevalence is higher than that given in Table III since by chance only one out of the five cases found in the survey came from the census sample on which the prevalence figures are based.)

Medical Care

Use of professional medical care in the past six months was reported by only 21% of those with conditions of a severity which was thought to justify treatment. On the other hand about one-tenth of those with only trivial conditions had sought treatment. This suggests a high degree of tolerance of skin disorders by the majority of people and a low tolerance by a minority. In this respect people with skin disease appear to behave in the same way as those with any condition with a low morbidity and mortality (McKinley, 1972). The decision whether to seek medical care is as likely to be determined by personal and cultural influences as by the severity of the condition.

It could be argued that the medical help which can be given for most kinds of skin disease is not great, and that many sufferers do not seek treatment because they have a low expectation of a successful outcome. That this is only a partial explanation is suggested by the finding that only 27% of those with moderate/severe eczema sought treatment. This is a condition which can nearly always be symptomatically alleviated by the use of topical steroids but these can be obtained only on a doctor's prescription.

Self medication was much more commonly used than professional medical advice. It is less likely to have been effective (although we have no measure of this) and it is more expensive; nevertheless availability appeared to outweigh the other disadvantages. At the time of the survey there was no prescription charge. It is an interesting observation on the provision of a free health service in a relatively affluent society that many preferred to pay for less effective remedies than go through the time-consuming machinery of obtaining professional medical advice.

The authors are well aware of the limitations of this survey, the chief of which was in standardizing the diagnoses, and grading the severity of the lesion seen. These difficulties were dependent on the necessity of employing a team of 17 observers varying in dermatological skills from specially trained nurse interviewers to highly skilled dermatologists.

Nevertheless the survey has been able to measure the exceedingly high prevalence of skin lesions in an urban adult population. Over one-fifth of the population under review was judged to have a moderate or severe skin lesion. Eczema thought to require treatment was observed in 6%, acne in 3·5%, and psoriasis in 0·6%. Nearly 40% of those interviewed had moderate or severe skin disease but only one-fifth of these had sought medical attention for skin disorders during the past six months and not more than 3·5% had been referred for a further opinion or treatment.

These figures present a challenge both to general practitioners and to dermatologists.

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APPENDIX

GROUPING OF DIAGNOSES
NO. OF THE VARIOUS CONDITIONS OBSERVED IN 614 PERSONS EXAMINED

Group	Trivial	Moderate	Severe	Total
1. *Tumours, naevi and angiomata* benign melanoma 61, papillomata and 'skin tags' 18, non-pigmented mole 16, pigmented naevus 17, fibroma or histiocytoma 17, non-pigmented raised lesions (unspecified) 7, haemangioma 10, telangiectasis 6, skin deposits or infiltrations 3, lipoma 2, rodent ulcer 1, pigmented raised lesion (unspecified) 1, neurofibroma 1, ?glomus tumour 1	146	14	1	161
2. *Eczema* eczema (unspecified) 30, varicose/gravitational eczema 18, contact dermatitis 22, focal eczema 10, seborrhoeic dermatitis/eczema 15, discoid/nummular eczema 6, pompholyx 2, atopic eczema 3, eczema secondary to fungus infections 1, occupational dermatitis 4	36	67	8	111
3. *Acne* acne vulgaris 68, sebaceous cyst or adenoma 8, other postacne scarring 4, acne keloid 3	40	42	1	83
4. *Scaly dermatoses (other than groups 2, 8, 11)* seborrhoeic keratosis 18, sycosis barbae 7, ichthyosis 7, keloid scar 7, other hypertrophic and atrophic conditions of skin 6, dry scaly skin (unspecified) 6, intertrigo 3, callosities (of foot) 9, (of hand) 1, striae atrophicae 2, pityriasis rosea 1, lichen planus 1	40	26	2	68
5. *Scalp and hair disorders* pityriasis capitis (dandruff) 45, folliculitis 11, alopecia areata 2, hirsuties 5, alopecia (unspecified) 5, atrophy of scalp 2, 'hair growing in' 1	51	18	2	71
6. *Prurigo and allied disorders* neuro dermatitis/lichen simplex chronicus 18, prurigo (unspecified) 9, pruritus ani 9, pruritus vulvae 8, urticaria 6, giant urticaria 1, dermatographia 1	26	25	1	52
7. *Erythematous and other dermatoses* abnormal pigmentation (various) 8, chilblains 7, acne rosacea 5, various other erythematous conditions 8, pemphigus vulgaris 1, lupus erythematosus 1, vitiligo 1, milia 1, purpura 1, peripheral vascular disease 1	17	17	0	34
8. *Infective or parasitic conditions* herpes zoster 2, herpes simplex 7, 'athlete's foot' 5, epidermophytosis 5, furuncle 7, paronychia 9, insect bites 1	23	13	0	36
9. *Infective warts* verruca vulgaris 32, molluscum contagiosum 1	29	4	0	33
10. *Nail disorders* gryphosis 9, ingrowing toenail 5, fungal infections of nail 4, deformed nails (unspecified) 3, discolouration of nails (unspecified) 1, clubbing of nails 1, psoriatic nails 1	13	11	0	24
11. *Psoriasis*	6	6	5	17
12. *Mouth and tongue conditions* aphthous ulcer 5, fissured tongue 2, cyst of lip 1	7	1	0	8
13. *Chronic ulcer* gravitational (varicose) ulcer 5	2	3	0	5